		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0009258

Facility Name: Good Samaritan Home

Address: 2130 Harrison Street (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: (217) 223-8717 **Fax #** (217) 223-6015

IDPA ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Judy Graham **Telephone Number:** (217) 223-8717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/99 to 9/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Michael Duffy
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Dennis G. Koch, CPA, CGFM
(Firm Name & Address) Wade Stables, P.C.
(Telephone) (217) 224-8484 Fax (217) 224-050- Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,836	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	132	48,312	3
4		Intermediate/DD			4
5	101	Sheltered Care (SC)	101	36,966	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	279	102,114	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,119	4,256	2,528	7,903	8
9	SNF/PED					9
10	ICF	20,458	34,848		55,306	10
11	ICF/DD					11
12	SC	4,042	25,052		29,094	12
13	DD 16 OR LESS					13
14	TOTALS	25,619	64,156	2,528	92,303	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.39%

D. How many bed-hold days during this year were paid by Public Aid?
328 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy - Pool Exercise Classes

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/22/1957

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 8 and days of care provided _____

Medicare Intermediary Adminis Stor Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: n/a Fiscal Year: 9/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	621,538	47,493	69,963	738,994	(164,350)	574,644		574,644			1
2	Food Purchase		583,480		583,480	(91,657)	491,823	(12,203)	479,620			2
3	Housekeeping	318,256	35,970	42,905	397,131	(23,453)	373,678		373,678			3
4	Laundry											4
5	Heat and Other Utilities			387,719	387,719		387,719	(125,166)	262,553			5
6	Maintenance	283,667	4,107	157,680	445,454	(20,495)	424,959	(54,663)	370,296			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,223,461	671,050	658,267	2,552,778	(299,955)	2,252,823	(192,032)	2,060,791			8
	B. Health Care and Programs											
9	Medical Director					48,064	48,064		48,064			9
10	Nursing and Medical Records	3,102,645	224,560	291,045	3,618,250	(282,741)	3,335,509		3,335,509			10
10a	Therapy	332,381	4,362	108,694	445,437	(23,805)	421,632	(11,941)	409,691			10a
11	Activities	113,414	3,616	21,402	138,432	(8,427)	130,005		130,005			11
12	Social Services	132,934	601	10,457	143,992	(9,738)	134,254		134,254			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,681,374	233,139	431,598	4,346,111	(276,647)	4,069,464	(11,941)	4,057,523			16
	C. General Administration											
17	Administrative	138,683		9,680	148,363		148,363		148,363			17
18	Directors Fees											18
19	Professional Services					198,592	198,592	(158,018)	40,574			19
20	Dues, Fees, Subscriptions & Promotions					28,432	28,432	(8,874)	19,558			20
21	Clerical & General Office Expenses	255,359	38,081	1,095,387	1,388,827	(984,084)	404,743	(3,705)	401,038			21
22	Employee Benefits & Payroll Taxes					1,163,396	1,163,396		1,163,396			22
23	Inservice Training & Education											23
24	Travel and Seminar					18,566	18,566		18,566			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			86,941	86,941	(47,638)	39,303	(12,636)	26,667			26
27	Other (specify):*											27
28	**TOTAL General Administration**	394,042	38,081	1,192,008	1,624,131	377,264	2,001,395	(183,233)	1,818,162			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,298,877	942,270	2,281,873	8,523,020	(199,338)	8,323,682	(387,206)	7,936,476			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Good Samaritan Home #0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			749,386	749,386		749,386	(279,275)	470,111			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					102,675	102,675	(102,675)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			749,386	749,386	102,675	852,061	(381,950)	470,111			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	46,786	3,421	3,662	53,869	(4,764)	49,105		49,105			40
41	Coffee and Gift Shops	17,841		27,303	45,144		45,144		45,144			41
42	Provider Participation Fee					97,722	97,722		97,722			42
43	Other (specify):*					3,705	3,705		3,705			43
44	**TOTAL Special Cost Centers**	64,627	3,421	30,965	99,013	96,663	195,676		195,676			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,363,504	945,691	3,062,224	9,371,419		9,371,419	(769,156)	8,602,263			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	12,203	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	2,137	6		6
7	Sale of Supplies to Non-Patients	11,941	10a		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Schedule	742,875			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 769,156		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 769,156		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Good Samaritan Home

ID# 0009258

Report Period Beginning: 10/1/99

Ending: 9/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Care Related Costs:	$		1
2	Depreciation	270,636	30	2
3	Utilities	125,081	5	3
4	Maintenance	51,538	6	4
5	Real Estate Taxes	100,419	33	5
6	Insurance	12,636	26	6
7	Disallowed Assets	1,431	30	7
8				8
9	Promotions and Dues	8,874	20	9
10				10
11	Rental Property Expense:			11
12	Depreciation	7,208	30	12
13	Utilities	85	5	13
14	Insurance	988	26	14
15	Real Estate Taxes	2,256	33	15
16				16
17	Other:			17
18	Investment Consultants	158,018	19	18
19	HCF Assessment	3,705	20	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
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64				64
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66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	742,875		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/1/99 **Ending:** 9/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	12,203	0	0	0	0	0	0	0	0	0	0	12,203	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	125,166	0	0	0	0	0	0	0	0	0	0	125,166	5
6	Maintenance	53,675	0	0	0	0	0	0	0	0	0	0	53,675	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	191,044	0	0	0	0	0	0	0	0	0	0	191,044	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	11,941	0	0	0	0	0	0	0	0	0	0	11,941	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	11,941	0	0	0	0	0	0	0	0	0	0	11,941	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	158,018	0	0	0	0	0	0	0	0	0	0	158,018	19
20	Fees, Subscriptions & Promotions	12,579	0	0	0	0	0	0	0	0	0	0	12,579	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	13,624	0	0	0	0	0	0	0	0	0	0	13,624	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	184,221	0	0	0	0	0	0	0	0	0	0	184,221	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	387,206	0	0	0	0	0	0	0	0	0	0	387,206	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/1/99 **Ending:** 9/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	279,275	0	0	0	0	0	0	0	0	0	0	279,275	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	102,675	0	0	0	0	0	0	0	0	0	0	102,675	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	381,950	0	0	0	0	0	0	0	0	0	0	381,950	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	769,156	0	0	0	0	0	0	0	0	0	0	769,156	45

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		None	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	None					$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	None						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	None'											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	86,706	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	108,240	2
3. Under or (over) accrual (line 2 minus line 1).	$	21,534	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	81,141	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	102,675	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	84,855	8
	1996	97,103	9
	1997	108,385	10
	1998	112,073	11
	1999	108,240	12

All Real Estate Taxes are considered non-care expenses

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Residential Cottage Apartments

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Main Campus	1,219,680	1956-1999	$ 128,278	1
2					2
3	TOTALS	1,219,680		$ 128,278	3

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements										9
10	Improvements			1974	26,525		30			26,324	10
11	Improvements			1984	49,187		15			49,187	11
12	Improvements			1985	29,707	1,515	20	1,515		22,741	12
13	Improvements			1986	72,453	3,549	20	3,549		53,222	13
14	Improvements			1988	19,174	890	20	890		12,048	14
15	Parking Lot			1992	4,257	213	20	213		1,490	15
16	Parking Lot			1993	46,071	2,304	20	2,304		17,470	16
17	Parking Lot			1994	87,827	5,855	15	5,855		39,522	17
18	Manhole/Sewer			1994	2,859	191	15	191		1,272	18
19	Sidewalk			1994	7,875	525	15	525		3,194	19
20	Lights/Front			1997	5,360	357	15	357		1,339	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 351,295	$ 15,399		$ 15,399	$	$ 227,809	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30		1957		$ 358,309	$		$	$	$ 358,309	4
5	75		1962		683,823	17,096	20	17,096		655,344	5
6	99		1973		1,683,761	42,094	40	42,094		1,132,004	6
7	75		1984		1,953,541	48,838	40	48,838		809,909	7
8											8
	Improvement Type**										
9	Building Improvements			1974	89,670	1,012	30	1,012		86,055	9
10	Building Improvements			1975	28,553					28,553	10
11	Building Improvements			1976	9,414					9,414	11
12	Building Improvements			1977	3,107					3,107	12
13	Building Improvements			1979	179					179	13
14	Building Improvements			1982	151,081	5,276	30	5,276		97,627	14
15	Building Improvements			1985	250,935	6,273	40	6,273		95,776	15
16	Building Improvements			1986	161,531	4,038	40	4,038		57,443	16
17	Building Improvements			1987	19,089	500	38	500		6,463	17
18	Building Improvements			1989	174,123	6,974	30	6,974		90,567	18
19	Garage Additions			1990	78,563	2,619	30	2,619		27,934	19
20	New Roof-North Wing			1990	43,980	2,199	20	2,199		22,906	20
21	Hall Renovations			1991	20,616	1,031	20	1,031		9,879	21
22	Building Improvements			1991	511,992	17,066	30	17,066		170,745	22
23	Ceiling/Partitions			1991	37,276	1,242	30	1,242		11,597	23
24	Office/Entrance			1991	14,768	738	20	738		7,384	24
25	Kitchen/Dining Room			1993	310,412	7,760	40	7,760		56,909	25
26	West Nursing			1994	66,876	3,343	20	3,343		20,062	26
27	Dining Room			1994	6,990	384	10	384		2,275	27
28	West Nursing			1995	128,327	6,416	20	6,416		35,824	28
29	West Nursing			1995	3,151	158	20	158		709	29
30	Gas Line			1996	3,062	153	20	153		689	30
31	Gutters			1996	10,817	541	20	541		2,434	31
32	Eber Wing Improvements			1996	20,335	1,017	20	1,017		4,576	32
33	Roof			1996	9,016	451	20	451		2,029	33
34	Roof-Anna Brown Wing			1996	70,800	3,540	20	3,540		13,865	34
35	Walls/Floor-Anna Brown Wing			1997	41,780	2,089	20	2,089		7,311	35
36	TOTAL (lines 4 thru 35)				$ 6,945,877	$ 182,848		$ 182,848	$	$ 3,827,878	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Freezer Floor			1997	4,394	259	17	259		1,035	9
10	Roof-Anna Brown Wing			1997	48,740	1,250	39	1,250		3,567	10
11	Roof-Kitchen/Dining			1998	45,550	1,168	39	1,168		3,208	11
12	Remodeling-Anna Brown Wing			1999	203,541	5,563	39	5,563		6,893	12
13	Roof-Chapel			1999	21,915	548	39	548		754	13
14	Remodeling-Eber Wing			1999	27,005	1,379	39	1,379		2,399	14
15	Remodeling-Chapel			2000	25,887	238	39	238		239	15
16	Remodeling-Kitchen			2000	11,683	390	15	390		390	16
17	Remodeling-East Nursing			2000	26,757	195	39	195		195	17
18	Smoke Damper-Eber Wing			2000	16,485	500	15	500		500	18
19	Lighting-Special Care			2000	14,260	476	15	476		476	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 446,217	$ 11,966		$ 11,966	$	$ 19,656	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Service Equipment:										9
10	Improvements			1973	38,904					38,904	10
11	Improvements			1978	5,714					5,714	11
12	Improvements			1979	9,188					9,188	12
13	Improvements			1980	1,596					1,596	13
14	Improvements			1982	17,350					17,350	14
15	Improvements			1983	10,058	503	20	503		8,634	15
16	Improvements			1984	816,496	17,227	20	17,227		753,585	16
17	Improvements			1985	184,917	8,421	20	8,421		145,123	17
18	Improvements			1986	137,391	6,241	20	6,241		89,091	18
19	Improvements			1987	21,221	1,061	20	1,061		14,142	19
20	Improvements			1988	14,400	697	20	697		12,133	20
21	Improvements			1989	6,469	535	15	535		6,299	21
22	Phones			1990	600	15	10	15		600	22
23	Building Service Equipment:			1991	83,893	7,668	10	7,668		76,274	23
24	Building Service Equipment:			1992	2,706	270	10	270		5,006	24
25	Building Service Equipment:			1993	20,910	1,113	10	1,113		9,753	25
26	Building Service Equipment:			1994	134,323	12,731	10	12,731		80,294	26
27	Building Service Equipment:			1995	22,482	2,079	10	2,079		11,879	27
28	Building Service Equipment:			1996	46,663	2,950	10	2,950		13,276	28
29	Building Service Equipment:			1997	130,986	7,223	10	7,223		22,237	29
30	Building Service Equipment:			1998	24,187	2,285	10	2,285		5,644	30
31	Building Service Equipment:			1999	158,316	20,100	7	20,100		30,114	31
32	Building Service Equipment:			2000	336,541	11,435	15	11,435		11,435	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,225,311	$ 102,554		$ 102,554	$	$ 1,368,271	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 2,005,104	$ 130,799	$ 130,799	$	Various	$ 1,617,942	37
38	Current Year Purchases	90,184	6,243	6,243		Various	6,243	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 2,095,288	$ 137,042	$ 137,042	$		$ 1,624,185	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Residents	Various	Various	$ 97,025	$ 15,928	$ 15,928	$	5	$ 50,506	42
43	Maintenance	Various	Various	73,691	4,374	4,374		5	64,485	43
44	Maintenance	Various	Various	1,220				5	1,219	44
45										45
46	TOTALS			$ 171,936	$ 20,302	$ 20,302	$		$ 116,210	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 12,364,202	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 470,111	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 470,111	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 7,184,009	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Cottages	$ 6,297,179	$ 163,416	$ 2,550,557	52
53	Furnishings	613,902	55,125	408,305	53
54	Land and Improvements	1,014,020	52,095	614,620	54
55	Rental Houses	294,323	7,208	17,226	55
56	Disallowed Assets	250,709	1,431	210,047	56
57	TOTALS	$ 8,470,133	$ 279,275	$ 3,800,755	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Good Samaritan Home **#** 0009258 **Report Period Beginning:** 10/1/99 **Ending:** 9/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 51,697	$	1
2	Cash-Patient Deposits	27,708		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	590,929		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,310,535		5
6	Prepaid Insurance	31,909		6
7	Other Prepaid Expenses	1,301		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,014,079	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	29,293,798		12
13	Land	280,541		13
14	Buildings, at Historical Cost	13,985,633		14
15	Leasehold Improvements, at Historical Cost	1,367,177		15
16	Equipment, at Historical Cost	5,200,988		16
17	Accumulated Depreciation (book methods)	(10,984,763)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Const in Progress	49,904		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 39,193,278	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 41,207,357	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 280,430	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,708		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	203,909		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,139		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Vacations	282,484		36
37	Advance Rents-Residents	489,742		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,365,412	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Advance Rents-Residents	1,115,062		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,115,062	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,480,474	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 38,726,883	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 41,207,357	$	48

***(See instructions.)**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 34,629,135	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 34,629,135	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,097,748	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,097,748	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 38,726,883	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,447,090	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,447,090	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	421,826	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 421,826	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	89,379	13
14	Non-Patient Meals	14,161	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,099,606	16
17	Sale of Drugs	467,736	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,670,882	23
	D. Non-Operating Revenue		
24	Contributions	730,702	24
25	Interest and Other Investment Income***	4,187,806	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,918,508	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	10,861	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,861	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,469,167	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,552,778	31
32	Health Care	4,346,111	32
33	General Administration	1,526,409	33
	B. Capital Expense		
34	Ownership	749,386	34
	C. Ancillary Expense		
35	Special Cost Centers	99,013	35
36	Provider Participation Fee	97,722	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,371,419	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,097,748	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,097,748	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,931	2,080	$ 48,064	$ 23.11	1
2	Assistant Director of Nursing	1,919	2,080	39,515	19.00	2
3	Registered Nurses	27,274	29,291	443,239	15.13	3
4	Licensed Practical Nurses	65,813	72,964	897,707	12.30	4
5	Nurse Aides & Orderlies	169,346	184,007	1,645,028	8.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,009	7,620	163,640	21.48	7
8	Rehab/Therapy Aides	14,171	16,924	168,741	9.97	8
9	Activity Director	1,943	2,080	18,694	8.99	9
10	Activity Assistants	11,251	12,190	94,720	7.77	10
11	Social Service Workers	14,549	16,423	132,934	8.09	11
12	Dietician					12
13	Food Service Supervisor	9,667	10,792	118,867	11.01	13
14	Head Cook	6,422	7,215	62,672	8.69	14
15	Cook Helpers/Assistants	48,110	52,345	371,910	7.10	15
16	Dishwashers	9,106	9,932	68,089	6.86	16
17	Maintenance Workers	32,690	36,254	283,667	7.82	17
18	Housekeepers	27,401	30,484	226,193	7.42	18
19	Laundry	10,923	12,019	92,063	7.66	19
20	Administrator	1,896	2,080	79,377	38.16	20
21	Assistant Administrator	1,936	2,080	59,307	28.51	21
22	Other Administrative	11,580	12,366	180,033	14.56	22
23	Office Manager					23
24	Clerical	7,310	8,271	75,325	9.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,930	2,142	29,092	13.58	31
32	Other Health Care(specify)					32
33	Other(specify) Beauty/Gift Shop	7,057	8,042	64,627	8.04	33
34	TOTAL (lines 1 - 33)	491,234	539,681	$ 5,363,504 *	$ 9.94	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 13,268	1	35
36	Medical Director		3,600	10	36
37	Medical Records Consultant		18,957	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,044	10	39
40	Physical Therapy Consultant		25,000	10a	40
41	Occupational Therapy Consultant		15,283	10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		2,388	10a	43
44	Activity Consultant		2,414	11	44
45	Social Service Consultant		719	12	45
46	Other(specify)				46
47	Dental Consultant		2,400	10	47
48					48
49	TOTAL (lines 35 - 48)		$ 94,073		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Duffy	Administrator	0	$ 79,377
Judy Graham	Asst Admin	0	59,306
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 138,683

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Schmeideskamp, et al	Legal	$ 12,644
Wade Stables, P.C.	Audit	15,150
American Express	Medicare	5,222
Loomis Sayles & Co	Investment	103,553
Delaware Co	Investment	17,300
1838 Fund	Investment	37,165
Altschuler Meiv	Medicare	7,558
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 198,592

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,638
Unemployment Compensation Insurance	1,957
FICA Taxes	393,448
Employee Health Insurance	362,508
Employee Meals	210,334
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	138,575
Employee Life Insurance	2,065
Employee Medical Expense	6,871
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,163,396

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	13,841
HHS	5,717
Chamber of Commerce	211
Promotions	8,663
Less: Chamber of Commerce	(211)
Less: Public Relations Expense	(8,663)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,558

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	18,566
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,566

**See instructions.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/1/99 Ending: 9/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/1/99 **Ending:** 9/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - $13,841

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 23,242 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 97,722
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 210,334 Has any meal income been offset against related costs? Yes Indicate the amount. $ 12,202

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Wade Stables, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

The Good Samaritan Home of Quincy
Schedule V - Reclassifications
Year Ended September 30, 2000

I.	Employee Meals Reclassified	Dietary	$ 118,677
		Food Purchases	91,657
	Allocated on basis of average cost of meals served		$ 210,334

II. Payroll taxes and employee benefits reclassified

	Payroll Taxes	Employee Benefits	Total
Dietary	$ 45,673	$ -	$ 45,673
Housekeeping	23,453	-	23,453
Maintenance	20,495	-	20,495
Nursing	227,806	-	227,806
Activities	8,427	-	8,427
Clerical	31,244	503,148	534,392
Social Services	9,738	-	9,738
Beauty Shop/General Store	4,764	-	4,764
Therapy	23,805	-	23,805
	$ 395,405	$ 503,148	$ 898,553

III.	Workers' compensation insurance reclassified	$ 47,638
IV.	Promotion and dues reclassified	$ 28,432
V.	Seminars reclassified	$ 18,566
VI.	Provider participation fees	$ 97,722
VII.	Real Estate Taxes reclassified	$ 102,675
VIII.	Medical Director's Salary reclassified	$ 48,064
IX.	Professional services reclassified	$ 198,592
X.	HCF Assessment	$ 3,705

Summary of Reclassifications

Dietary	$ (164,350)
Food Purchases	(91,657)
Housekeeping	(23,453)
Maintenance	(20,495)
Nursing	(282,741)
Activities	(8,427)
Fees and Subscriptions	28,432
Clerical	(984,084)
Employee Benefits and Payroll Taxes	1,163,396
Travel and Seminars	18,566
Insurance	(47,638)
Barber/Beauty Shop	(4,764)
Social Services	(9,738)
Therapy	(23,805)
Professional Services	198,592
Provider Participation Fees	97,722
Medical Director	48,064
Real Estate Taxes	102,675
Other	3,705
	$ -

Schedule XVII - Line 28, Miscellaneous

Cottage services income	$ 2,150
Application fee income	4,525
Miscellaneous income	3,125
Discounts	1,061
	$ 10,861